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1. Itemized charges for the admission.

2. Utilization review notes, physician's orders and discharge summary.

3. A copy of UB-92 claims on the admission.

4. A copy of the paid remittances on the admission.

After utilization review, the Department will use the following methodology to determine the amount of any additional reimbursement to be allowed:

(a) For all hospitals, except freestanding children's hospitals in the State of Georgia, the threshold amount will be computed using an average of charges for the five (5) most expensive inpatient admissions in the hospital's base year, trended to the reimbursement year using inflation factors. Effective July 1, 1989, and after the cost outlier threshold for freestanding children's hospital's in the State of Georgia is $50,000.

(b) If the hospital's base year costs-to-charges ratio is less than the reimbursement year to date payments-to-charges ratio, the appeal for additional reimbursement will be denied. Quarterly payment adjustments made to disproportionate share hospital providers will not be considered when determining the payments-to-charges ratio during outlier review.

(c) If the hospital's base year costs-to-charges ratio exceeds the reimbursement year to date payments-to-charges ratio, the Department will pay the total covered charges for outlier minus threshold, to which the base year costs-to-charges ratio (maximum of 75%) is applied less any adjustment and the regular per case amount already paid.

Allowable Outlier Charges
MINUS [Threshold]
EQUALS Excess Charges
TIMES C/C Ratio (Max. 75%)
EQUALS Excess Charges Reduced to Cost
MINUS [Adjustment]
MINUS [Regular Per Case Rate]

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EQUALS Additional Payments

(d) Hospitals with a base year cost-to-charges ratio of 100% or more will receive excess charges as computed in (c) above, without application of the cost-to-charges ratio.

(e) The hospital's per case payment and charges for the outlier in question will be included in the ratio computed in (c) and (d) above.

Day outlier reimbursement for enrolled Georgia hospital is explained at Section IV.G. above. Outlier reimbursement for enrolled non-Georgia hospitals is explained at Section IV.A.2. above.

XI. Swing-Bed Services

A. Reimbursement Methodology

Swing-bed providers will be reimbursed a prospective rate per patient day which will be the statewide average Medicaid rate per diem paid to Level I nursing facilities for routine services furnished during the previous calendar year. The per diem rate covers the cost of certain routine services as described in Attachment 3.1A, page 1c-3 of the Plan. Ancillary services such as laboratory, radiology, and certain prescription drugs must be billed and reimbursed separately under the appropriate Medicaid program. For example, radiology services provided in the outpatient department of the hospital should be billed as outpatient hospital services. Providers must bill on a monthly basis.

Medicaid will reimburse the Medicare Part A coinsurance for skilled level of care swing-bed services provided to Medicaid/Medicare recipients.

Medicaid reimbursement will be reduced by the amount of the recipient's liability (patient income). Patient income is established by the county DFACS office and is the dollar amount shown on Form DMA-59, or the dollar amount shown on Form DMA-286 if the recipient has Medicaid/Medicare coverage. The patient's income is deducted in full from the Medicaid reimbursement rate until the income has been exhausted.

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B. Cost Report and Cost Settlement

There will not be a year-end cost settlement process for the swing-bed services program. In addition, there is no swing-bed services cost report. Medicaid Swing-Bed program data should not be included in the Medicaid Hospital program cost report settlement data. The Medicaid routine swing-bed days should be excluded from the hospital's Medicaid routine days on Worksheet D-1, Part I of the cost report.

XII. Hospital Crossover Claims

Effective with dates of payment of October 1, 1990, and after, the maximum allowable payment to enrolled Georgia and non-Georgia hospitals for Medicare inpatient deductibles and coinsurance (crossover claims) will be the hospital-specific Medicaid per case rate. The maximum allowable payment to non-Georgia hospitals not enrolled in the Georgia Medicaid program for Medicare inpatient crossover claims will be the average hospital-specific inpatient per case rate for enrolled non-Georgia hospitals.

XIII. Nonallowable Costs

The costs listed below are nonallowable. Reasonable costs used in the establishment of rates effective on and after July 1, 1991, will reflect these costs as nonallowable.

1) Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;

2) Memberships in civic organizations;

3) Out-of-state travel paid by the provider for persons other than board members of those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

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4) Vehicle depreciation or vehicle lease expenses in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limit shall not apply to specialized patient transport vehicles (e.g., ambulances);

5) Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient care staff or patient transport is nonallowable;

6) Fifty percent (50%) of membership dues for national, state, and local associations;

7) Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Department or any other state agency when judgement or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable; and

8) Advertising costs that are (a) for fund-raising purposes, (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation, (c) for the purpose of increasing patient utilization of the provider's facilities, (d) for public image improvement, or (e) related to government relations or lobbying.

XIV. Day Outliers

Effective with dates of admission beginning July 1, 1991, and after, all non-disproportionate share hospitals will be eligible to receive an outlier payment adjustment for medically necessary inpatient hospital admissions involving exceptionally long lengths of stay for individuals under age one. To qualify for this day outlier payment, the length of stay for individuals under age one must exceed the hospital-

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specific threshold, which is defined as the mean length of stay plus three standard deviations. The day outlier payment will equal the number of days stay in excess of the threshold times the hospital-specific per admission rate per day. This rate per day will be the hospital-specific per case rate divided by the hospital-specific average length of stay for all Medicaid admissions. The base period used for calculation of the threshold and the per admission rate per day will be the period on which the hospital's prospective per case rate is based.

XV. Co-Payment

Effective with dates of admission of July 1, 1994, and after, a co-payment of $12.50 will be imposed for certain inpatient hospital admissions.

Recipients affected by the copayment are limited to adult recipient of Supplemental Security Income (SSI) benefits, certain other adult disabled and aged recipients and parents of children receiving Aid to Families with Dependent Children (AFDC) benefits. Children under age twenty-one, pregnant women, nursing home residents, or hospice care participants are not required to pay this copayment. Emergency services and Family Planning services received by Medicaid recipients do not require a copayment. Services cannot be denied based on the inability to pay these copayments.

XVI. Administrative Days

Administrative days are those days that a recipient remains in acute care setting awaiting placement in a nursing facility due to the unavailability of a bed. Administrative days may occur in the two situations outlined below.

- Following the physician's written order for discharge on the chart.
- When a utilization review denial letter is given prior to the physician's written order for discharge.

The allowable covered number of administrative days is three or 72 hours for either situation outlined above. Any days greater than three that a recipient remains in the acute care setting awaiting placement in a nursing facility are noncovered days.

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XVII. DRG Prospective Payment System

1. Effective October 9, 1997, the Georgia Department of Medical Assistance (DMA) will reimburse qualified providers for inpatient hospital services under the prospective payment system as set forth in this plan.

2. All inpatient services associated with admissions occurring on or after October 9, 1997, furnished by hospitals, are subject to the "Hybrid DRG Prospective Payment System" (hereafter referred to as the Hybrid DRG System).

3. Payment for all inpatient hospital services (as defined by the DMA Policy Manual) are reimbursed through the Hybrid DRG system either:

   (a) an amount per discharge (per case) for a diagnosis related group (hereafter referred to as the DRG system or DRG portion of the hybrid system), or

   (b) an amount per discharge (per case) based on claim-specific allowable charges multiplied by a hospital-specific cost-to-charge ratio (hereafter referred to as the cost-to-charge (CCR) system or CCR portion of the hybrid system).

4. The DRG portion of the hybrid system consists of DRG categories whose cases have sufficient volume, are relatively homogeneous, and are not considered to be highly specialized in nature. The CCR portion of the hybrid system consists of DRG categories whose cases are infrequent or highly variant.

5. Under both the DRG and CCR portions of the hybrid system, the DRG and CCR payments reflect reimbursement for operating costs. Capital costs and direct graduate medical education costs (when applicable) are paid based on a hospital-specific prospective per case basis. These per case add-on rates are uniform for a given hospital regardless of whether the operating portion of the case is paid under the DRG or CCR portion of the system.

6. For discharges paid under the DRG system, Georgia-specific relative weights and base rates are used. The Health Care Financing Administration (HCFA) Grouper version 14.0 is used to classify cases into DRG categories. For each DRG, relative weights are calculated by dividing the average operating cost for a specific DRG by the overall average operating cost across all cases included in the DRG system.

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7. As provided for in Section III of this plan, outlier payments are available under the DRG system for cases exhibiting unusually high costs for the hospital stay. In addition to unusually high cost cases, special payment provisions are made for cases involving a patient transfer from one facility to another or readmission of patients after an early discharge. Reimbursement for outlier cases are paid according to the reimbursement methodology set forth in Section III.

8. Payments for short stay cases, where a patient is discharged within one day of their admission to a facility, will be made based on DMA's policy regarding the definition of inpatient and outpatient cases.

9. DRG per discharge operating base rates will be adjusted according to the percentage of estimated non-outlier payments above or below a hospital's non-outlier operating costs per case. For DRG per discharge cases, on a per case average, losses will be limited to 90 percent of non-outlier operating costs and gains limited to 110 percent of non-outlier operating costs.

10. Reimbursement for disproportionate share hospitals will be made outside of the Hybrid DRG System.

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I. Data Sources and Preparation of Data for Computation of Prospective Rates

The calculation of prospective rates requires the use of historical claim and cost data and the calculation of rate components. These rate components are used in the calculation of the prospective rates as described in Section II of this plan.

A. Data Sources

The following describes the data sources that are used for the development of the necessary prospective rate components:

1. Historical Claims Data

Hospital inpatient claims data for dates of service July 1, 1994 through June 30, 1995 were utilized for the calculation of the base rates and the DRG relative weights.

2. Cost Report Data

The most recently audited HCFA Medicare cost report (through hospital fiscal year 1994) was used. This data was utilized for the calculation of the hospital-specific cost-to-charge ratios, the capital add-on rates and the direct graduate medical education (GME) add-on rates.

3. Capital Survey Data

The capital survey has historically been used by the Georgia Department of Medical Assistance (DMA) to collect information about hospital capital expenditures that have occurred in the time period since the most recent cost reporting period. For the purpose of calculating the hospital-specific capital add-on rate within the Hybrid DRG system, the capital survey information was used to supplement the cost report information by incorporating capital expenditures that occurred more recently than the base year. Therefore, capital survey data was collected for the period after the hospital cost report period to the present.

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4. Certified Registered Nurse Anesthetist (CRNA) Survey Data

DMA reimburses hospitals for CRNA costs using rates outside of the inpatient hospital reimbursement rates. Therefore, it is necessary to remove CRNA costs from the cost report data prior to calculating the rate components within the Hybrid DRG system. The survey data collected by DMA coincides with the cost reporting period utilized and provides the information necessary to identify and remove CRNA costs as necessary.

B. Preparation of Data

The following describes the general preparation of historical claims and cost data and the subsequent calculations of the necessary components used to compute rates:

1. Data Quality Analysis

An assessment is made of the quality of the data and the following exclusions are made from the historical claims database used to calculate the prospective rates:

(a) Cases with unusually low charges
(b) One day or same day discharges
(c) Medicare crossover claims
(d) Denied claims or claims with paid amounts equal to 0

2. Determination of Claim Costs

Allowable costs for each claim are computed by multiplying the hospital cost-to-charge ratio by the allowable charges from the claim. Using the hospital cost reports, overall operating cost-to-charge ratios are computed for each hospital. These cost-to-charge ratios are applied to the historical allowed claim charges to compute the allowable claim costs. Total facility cost-to-charge ratios exceeding 1.0 are limited to a value of 1.0.

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3. Inflation

Since inflation indices are necessary to adjust costs so that they more accurately reflect costs for the rate year, both direct graduate medical education add-ons and claim costs used in the calculation of the DRG system rate components were inflated to the midpoint of the rate year. Georgia has historically used the DRI inflation factor minus one percent as the inflation adjustment factor. Therefore, the DRI Type Hospital Market Basket minus one percent is used as the inflation factor. This one percent, annualized over the period equals 3.3 percent. The inflation factors used to inflate costs from state fiscal years 1995 through 1998 are as follows:

| Period | DRI Type Hospital Market Basket (minus 1% annually) |
|---|---|
| 7/1/94 - 6/30/95 | 2.1 % |
| 7/1/95 - 6/30/96 | 2.2 % |
| 7/1/96 - 6/30/97 | 1.1 % |
| 7/1/97 - 7/30/98 | 1.4 % |

Each claim is inflated to the midpoint of the rate year (February 18, 1998). Because the historical claims data covers the period of July 1, 1994 through June 30, 1995, the inflation of claim costs requires different inflation factors for the different dates of service. For example, a claim with a service date falling in July 1994 requires a larger inflation adjustment than a claim that falls in May 1995 (closer to the rate year). Each facility's graduate medical education costs were also inflated in the same manner in order to compensate for the different fiscal year ends.

In addition, an intensity allowance equal to the total calculated payment adjustment percentage is applied to the projected cost of services for Georgia Medicaid patients for disproportionate share hospitals, effective with admissions October 9, 1997 and after.